Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for date of service 05/17/01.
   b. The request was received on 05/14/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFAs-1500
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60
   b. HCFAs-1500
   c. EOBs
   d. Medical Records
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 06/25/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 06/28/02. The 14 day response from the insurance carrier was received in the Division on 07/12/02. Based on 133.307 (i) the insurance carrier's response is untimely so the Commission shall issue a decision based on the request and the carrier's initial response.

4. Notice of a letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 05/13/02
   "On 5-17-01, Dr. ___ provided professional anesthesia services to claimant, ___ for a Caudal Epidural Steroid Injection. Our charges were filed using CPT code 00630…. we were denied for our services stating code 'N – NOT APPROPRIATELY

DOCUMENTED REPORT SUBMITTED DOES NOT APPEAR TO SUBSTANTIATE LEVEL OF SERVICE BILLED, RECODE AND RESUBMIT FOR AUDIT [sic]….we received a [sic] another denial for our services,…with a denial code of 'N' with a comment of 'NOT APPROPRIATELY DOCUMENTED' and another description stating 'SERVICES RENDERED IS I.V. SEDATION AND MONITORING WHICH DOES NOT SUPPORT THE LEVEL OF SERVICE FOR 00630, SUGGEST CODE 01999'."

2. Respondent: No position statement noted in initial response. Fourteen day response is untimely.

IV. FINDINGS

1. Based on Commission Rule 133.307 (d) (1) (2), the only date of service eligible for review is 05/17/01.

2. The Carrier denied the disputed services by codes, "N – NOT APPROPRIATELY DOCUMENTED REPORT SUBMITTED DOES NOT APPEAR TO SUBSTANTIATE LEVEL OF SERVICE BILLED. RECODE AND RESUBMIT FOR AUDIT." and "D – DENIAL AFTER RECONSIDERATION N- NOT DOCUMENTED RE-EVALUATION NO ADDITIONAL RECOMMENDED ALLOWABLE *PLEASE NOTE THAT THIS IS A RE-EVALUATION OF THE FOLLOWING CHARGE(S):385714-7 SERVICE RENDERED IS IV SEDATION AND MONITORING WHICH DOES NOT SUPPORT THE LEVEL OF SERVICE FOR 00630 SUGGEST CODE 01999."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$ (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
05/17/01	00630	$825.00	$0.00	N	$40.00 per unit	MFG; General Instructions (I) (A) (B); CPT descriptor	Even though the report indicates I.V. sedation as opposed to MAC, the Anesthesia Ground Rules do not make a distinction between types of anesthesia. The CPT codes are per body areas not types of anesthesia. Therefore, reimbursement in recommended in the amount of **$825.00.**
Totals		$825.00	$0.00				The Requestor is entitled to reimbursement in the amount of **$825.00**.

The above Findings and Decision are hereby issued this 23rd day of October 2002.

Donna M. Myers
Medical Dispute Resolution Officer
Medical Review Division

DMM/dmm